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CMC01004

Rev. 02/05

**CHILDREN'S MEDICAL CENTER**

1935 Medical District Drive • Dallas, Texas 75235  
 7609 Preston Road • Plano, Texas 75024  
Dallas (214) 456-7000 Legacy (469) 303-7000

**Authorization for Disclosure of Protected Health Information**

MED REC NO. \_\_\_\_\_ ACCT NO. \_\_\_\_\_

PATIENT \_\_\_\_\_

DATE \_\_\_\_\_ LOCATION \_\_\_\_\_

DOB \_\_\_\_\_

I certify that I am the Patient or the (Legal Representative) (Father) (Mother) of the Patient, and I hereby authorize work force members of CHILDREN'S MEDICAL CENTER DALLAS ("Children's") to disclose the following protected health information from the record(s) of the Patient:

**Information to be disclosed:**

- Discharge Summary
- History and Physical
- Progress Notes
- Outpatient Clinic Visits (Dates) \_\_\_\_\_
- Other (Specify) \_\_\_\_\_
- Psychiatric / Psychological
- Operative Report
- Lab, X-Rays, Pathology, EKG, EEG, CT Scan
- Doctor's Orders
- Nurse's Notes
- Entire Hospital Record
- Other Hospitals

I understand that the records disclosed pursuant to this authorization form may include information relating to: Human Immunodeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome ("AIDS"); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

**This information may be disclosed to:**

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

I understand that the purpose(s) of the requested disclosure is (are):

- At the request of the Patient or Legal Representative
- Other: \_\_\_\_\_ (Specify)

**CHILDREN'S MEDICAL CENTER DALLAS** is hereby released from legal responsibility or liability for the disclosure of the records to the extent indicated and authorized herein. I also understand that I may revoke this authorization in writing at any time (except to the extent that action has been taken in reliance on this authorization) by sending a written notice to the Privacy Officer, 1935 Medical District Drive, Dallas, Texas 75235, or faxing a written notice to the Privacy Officer at 214-456-5299.

Unless otherwise revoked, this authorization will expire 180 days from the date of my signature or as otherwise specified by an event related to the Patient or the purpose of the disclosure as follows: \_\_\_\_\_

I understand that Children's may not condition treatment on my completion of this authorization form.

I understand that the information may no longer be protected by federal and state privacy law once it is disclosed and, therefore, may be subject to re-disclosure by the recipient.

\_\_\_\_\_  
Signature of Parent or Patient's Legal Representative

\_\_\_\_\_  
Legal Representative's Authority to Act for Patient

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

**TO RECIPIENT OF SUBSTANCE OR ALCOHOL ABUSE RECORDS:** This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.